WORLD HEALTH ORGANIZATION

TOBACCO ALERT

JULY 1995

MESSAGE

ACCEPTANCE SPEECH FROM PRESIDENT NELSON MANDELA ON RECEIVING THE TOBACCO OR HEALTH COMMEMORATIVE MEDAL AND CERTIFICATE

I am honoured to receive this medal today, May 31, **World No-Tobacco Day.** I also lend my personal support to the Tobacco or Health Programme of the World Health Organization.

Tobacco poses one of the most critical challenges to public health in our time. If current trends continue, millions of the world's children will die prematurely from diseases caused by tobacco. This preventable tragedy must be averted.

Tobacco is both a health and an economic problem. Some sectors of society — manufacturers, farmers, retailers and advertising agencies — certainly benefit from tobacco sales. But against this, are the economic losses — from premature deaths of breadwinners, from medical treatment, from lost industrial productivity and absenteeism caused by tobacco-related diseases, and from fires caused by carelessly discarded smoking materials.

There are also some costs that cannot be quantified — the reduced quality of life for smokers

and their families. The loss of speech because of throat cancer or of a limb from vascular disease. There are also the spouses of smokers who spend their last years alone because of the early death of a loved one who would not, or could not stop smoking.

In South Africa, we will celebrate the Day with action. On May 31, new tobacco labelling regulations will come into effect. These regulations will help ensure that everyone — and certainly everyone that smokes — is aware that "Smoking Kills".

On May 31, I again call on smokers to quit for one day, as a first step towards stopping for good.

I call on youth not to take up this deadly addiction. The time has come for governments, communities and individuals to build a healthy tobacco-free world.

Tobacco costs more than we think.

Nelson Mandela

President of the Republic of South Africa

(Speech delivered by Dr N C. Dlamini-Zuma, Minister of Health, South Africa)

CHILD HEALTH 2000

CHILD HEALTH 2000

SECOND WORLD CONGRESS AND EXPOSITION

All messages and speeches in this newsletter are from the official ceremony to launch World No-Tobacco Day 1995 which took place during the 2nd World Congress & Exposition in Vancouver, Canada.

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FROM JAMES CARTER, FORMER PRESIDENT, USA

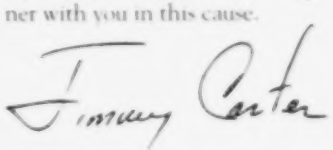
I wish I could be with you for this important celebration of **World No-Tobacco Day.** I commend you for your efforts to prevent children and youth from smoking, a problem that continues to grow internationally.

The topic of this year's **World No-Tobacco Day,** the economics of tobacco, is inextricably linked with child health. Tobacco companies target children and adolescents with advertising, luring youngsters into the trap of life-long addiction to cigarettes, while assuring large profits for the manufacturers. The costs to society for health services to treat smoking-related disease vastly surpass the profits made by the tobacco producers.

The great burden the health community carries because tobacco interests refuse to acknowledge the proven connection between smoking, debilitating disease, and early death is ethically and morally wrong. Each year there are more scientific reports about the devastating consequences of smoking, especially for our youth.

If young people do not smoke as adolescents, they are not likely to smoke as adults. Yet, 89% of smokers become addicted to cigarettes by the age of 18. And it is very difficult for children and teenagers to stop smoking once they become addicted.

I strongly endorse efforts to discourage children and adolescents from smoking, to limit their access to tobacco products, to ban advertising aimed at children and youth, and to control nicotine levels in tobacco products. The partnerships you have formed to address these issues are necessary and vital to fight the powerful influence of the tobacco industry. You can consider me a full partner with you in this cause.



Jimmy Carter

(Speech delivered by Mr William Foege)

EXCERPTS FROM THE ADDRESS BY DR HIROSHI NAKAJIMA, DIRECTOR-GENERAL, WORLD HEALTH ORGANIZATION

According to WHO estimates, there are more than 1 billion smokers in the world today. About 200 million men in developed countries and 700 million in developing countries are smokers. Among women, there are about one hundred million smokers in developed countries, and an approximately equal number in developing countries. Globally, 48% of men and 12% of women are smokers. In the developed countries, 41% of men and 21% of women smoke while in developing countries about 50% of men smoke compared with 8% of women.

In the course of a year, worldwide, tobacco kills about 3 million people, 2 million of whom live in developed countries and 1 million in developing countries. If current smoking patterns persist, in three to four decades, the annual toll from tobacco use worldwide will rise from 3 to 10 million deaths. Currently, in developed countries, smoking is the cause of about 36% of men's deaths and 13% of women's deaths before the age of 70. On average, smokers who die before the age of 70 lose 22 years of life expectancy.

Of great concern to us, the rapid growth in tobacco use in many developing countries will dramatically worsen this global picture. Thus, it can be expected that the developing countries' share in the overall mortality burden will increase sevenfold, from 1 million at present to 7 million deaths a year by the 2020s or 2030s.

In the case of HIV/AIDS, there is a lag-time of about 10 years between the infection and the explosion of the AIDS epidemic as such. In the case of tobacco, the evolution is much more insidious. It has been estimated that the peak in mortality will follow the peak in smoking prevalence by 30 years. Then, the full irreversible impact of the tobacco epidemic becomes apparent nationwide.

Faced with such alarming figures and prospects, WHO is determined to do everything possible to help countries contain the spread and reduce the impact of the tobacco pandemic. This determination will be reflected in the **Tobacco or Health** Plan of Action for 1996-2000, currently in preparation.

WHO and its governing bodies have been advocating comprehensive and multifaceted strategies in

MORE THAN 1 BILLION SMOKERS IN THE WORLD TODAY

MEN	WOMEN
200 million in developed countries	100 million in developed countries
700 million in developing countries	100 million (approximately) in developing countries

order to bring about a tobacco-free world. Such comprehensive strategies have two main objectives:

- first, to prevent people, mostly children and adolescents, from starting to smoke; and
- second, to help people quit smoking.

In order to achieve these two objectives, we must combine a number of educational, legislative and fiscal measures. **Health education** must be used to create a healthy and tobacco-free environment, within the family, in public places and transport, as well as at the work place. We must help reduce **peer-pressure** among children and adolescents so that they are not socially forced into acquiring the habit. We must also emphasize the importance of a **non-smoking family** environment, to protect children from such social pressure and also from the health damage caused by direct and indirect exposure to smoking. **Legislation** should be passed and enforced to eliminate tobacco **advertisements**, to require strong warnings on packages and, ideally, to require **neutral packaging**, as this should be decisive in helping us to reduce the social acceptability of smoking. We must be aware that the tobacco industry relies more on brand loyalty than on price competition and uses aggressive advertisement and publicity campaigns to promote tobacco consumption in general and its social acceptability in particular.

Legislation must also come into play to **restrict access** to tobacco-products, including to vending-machines, and to ban smoking in public places. WHO has been vigorously promoting the enforcement of a **tobacco-free environment** in all United Nations agencies and conferences. We also applaud the resolution of the **International Civil Aviation Organization** to propose to ban smoking on all international flights which, in fact, meets the demand of a vast majority of airline passengers.

The economic consequences of tobacco use are being documented in a growing number of countries, demonstrating that overall costs for the community many times exceed the short-term economic benefits which producers derive from tobacco sales. The economic losses incurred have been reported in many developed countries, and new studies are emerging in such countries as the People's Republic of China, Egypt, Malaysia, South Africa, and Venezuela, which show that, in most developing countries, tobacco use is also causing large economic losses.

Worldwide, experience has shown that effective measures are available and can be enforced to reduce tobacco consumption. **Economic measures** in particular, such as increased **taxes on tobacco**, have given us some of our most impressive victories in public health campaigns to date. To be fully effective, however, they must be coupled with well-balanced approaches to advertising which has a major influence on tobacco consumption. In addition, tobacco taxation should not be perceived as just another source of revenue for the State. As legislation is passed to ban or restrict tobacco advertisement, supportive measures must also be taken to help the media, arts and sports institutions overcome the economic losses thus incurred. For example, we should associate the media more actively with our health promotion campaigns. Here again, revenue collected from tobacco taxation can be put to good use.

Through taxation, government finance departments can help to reduce tobacco consumption or, at the very least, slow down its rate of growth.

Tobacco taxes can generate substantial revenue. Additional tobacco tax revenue should be used as part of **comprehensive tobacco control strategies** and reinvested, for example:

- to fund health care and health promotion;
- to fund alternative economic activity for tobacco farmers;
- to fund other non-tobacco-related government programmes;
- to sponsor sports events and arts groups;
- to involve the media in health promotion campaigns; and
- to reduce other taxes.

SMOKING KILLS 3 MILION ADULTS EACH YEAR

SMOKING CAUSES...

About 36% of men's deaths

About 13% of women's deaths before 70 years

SMOKERS...

who die before the age of 70 lose 22 years of life expectancy

TOBACCO USE...

results in a global loss of US$ 200 billion per year

THE SMOKER

GLOBAL

48% Men

12% Women

DEVELOPED COUNTRIES

41% Men

21% Women

DEVELOPING COUNTRIES

50% Men

8% Women

By reducing tobacco consumption, tobacco taxation will result in:

- a reduction in productivity losses;
- a reduction in the health care burden; and,
- a reduction in the human misery associated with unnecessary death and illness.

The tobacco industry remains entrenched in its opposition to the promotion of improved public health through strengthened tobacco control measures. But this opposition should not deter us from advocating more effective use of tobacco taxation as one key element in what must be comprehensive tobacco control strategies. Health-oriented tobacco control policies which act simultaneously on tobacco taxation and advertising will help us redress the balance and achieve our goal of a tobacco-free world. When the Finance Ministries, Health Ministries, legislative bodies, health professionals, teachers and parents work closely together in developing and implementing such strategies, real and decisive progress can be achieved in controlling the tobacco pandemic. Then, more and more of today's children will be able to live happy, healthy and smoke-free lives as tomorrow's adults.

CONTROLLING TOBACCO: LET'S DO IT FOR THE CHILDREN

I can think of no more appropriate place to be discussing tobacco or health issues than at this landmark global conference — Child Health 2000. In most areas of the world, the overwhelming majority of people who begin to use tobacco products do so during adolescence. In Canada and many other countries, over 90 % of people who start smoking do so while they are still teenagers.

Since most tobacco use begins in adolescence, and quickly becomes intractable because of tobacco's powerful addictive properties, I can only echo the words of Dr David Kessler, Commissioner of the United States' Food and Drug Administration who recently said, "Nicotine addiction begins when most tobacco users are teenagers, so let's call this what it really is: a paediatric disease."

The statistics are sobering. It is estimated that, of all beginning smokers who start using tobacco in adolescence and continue smoking throughout their lives, half will be killed by tobacco, and half of those will succumb to a fatal tobacco-caused disease before age 70. Those who die before age 70 from a tobacco-related cause will lose, on average, 22 years of life expectancy. If current smoking trends persist, WHO estimates that we can expect 200-300 million under 20 currently alive to eventually be killed by tobacco.

Of course the key to lessening the impact of this looming epidemic is primary prevention. For every two children who are prevented from ever becoming lifelong smokers, one future tobacco-related death will be prevented. At the limit, the epidemic of tobacco-caused mortality would eventually disappear entirely, provided that, henceforth, no one ever started to smoke.

It is, of course, far easier to state this noble objective than to actually accomplish it. It would be very tempting, for example, to concentrate all efforts on health promotion and education aimed at children in efforts to persuade them not to take up the habit. But caution is needed. Decades of experience have shown that this strategy, by itself, will not stamp out the tobacco epidemic.

How is the cycle to be broken? WHO's governing body, the World Health Assembly, has adopted a series of resolutions that add up to a call for Member States to adopt comprehensive tobacco control policies and programmes that will simultaneously address all aspects of the tobacco problem.

Health care professionals have key roles to play in helping to slow the progress of the tobacco epidemic. Their roles extend beyond counselling their patients and clients to avoid tobacco use; their roles extend beyond following their own advice through living their own lives free from tobacco; they extend beyond working to ensure the health care institutions in which they work are smoke-free. The tobacco epidemic is so serious that health care professionals can and must help even more, by becoming public health advocates, speaking out in favour of implementation of World Health Assembly resolutions for tobacco control, and not resting until real progress is achieved.

Tobacco consumption among children will decrease the world over when our children see more consistency in the way the adult world approaches tobacco. Tobacco use is so widespread that making it illegal cannot be realistically contemplated. Nevertheless, when both the words and deeds of adults in general, as well as the adult institutions of justice, law, government, business, industry, education and health care, all show greater consistency in favour of lives free from tobacco use, more and more children will make the healthy choice to remain non-smokers.

I look forward to the day when the success achieved in decreasing tobacco use among youth is repeated in not just a few countries, but in all countries. I challenge everyone to join with WHO by acting in ways both large and small to help slow the progress of the tobacco epidemic. The future good health of our children will depend in large measure on our collective success at controlling the tobacco epidemic.

Let's do it for the children.

Dr Hu Ching-Li
Assistant Director-General
World Health Organization

EXCERPTS FROM THE STATEMENT BY THE HONOURABLE DIANE MARLEAU, MINISTER OF HEALTH, CANADA

Tobacco addiction knows no borders. It does not discriminate on the basis of gender or age. Tobacco now kills 3 million people each year worldwide. That represents 30 million preventable deaths in this decade alone. This devastating toll is projected to rise to 10 million a year over the next 30 to 40 years.

The increasing use of tobacco in developing countries will result in enormous health, economic and environmental costs over the long term. It is in the interest of all countries to help the people and governments of those countries to counter this negative development.

If we are to stop this global trend toward increased tobacco use and addiction, we must focus on the world's youth. We know that the great majority of today's smokers began to smoke in their teens, and often earlier. In Canada, we have managed to reduce overall tobacco use. But our success with some groups, particularly young Canadians, has been limited and even negated by factors such as peer pressure and the alluring and intensive marketing efforts of the tobacco industry.

Child and teen addiction to harmful substances — any harmful substances, including tobacco — is something that we must work to prevent.

The task is not an easy one. We are dealing with an addictive product on which billions of dollars are spent each year to promote sales. But we have learned some valuable lessons in this country on how to reduce consumption along the way. We want to ensure that other countries are aware of them in order that they may benefit from our experience. In Canada we are using legislation, research and education to help youth remain or become smoke-free.

Our involvement with the tobacco issue has taught us that a tobacco control strategy must be comprehensive. It must also be collaborative; that is, it must involve different levels of government, the health and medical communities and interested individuals in the struggle against tobacco addiction. This approach may provide a model for efforts at the international level.

This is a time to renew our commitment domestically and to take on new commitments internationally. We will continue to share our experience and our knowledge with the world health community.

MEDALISTS

EXCERPTS FROM THE SPEECH BY DR STANLEY INDERSON, THE MINISTER OF HEALTH OF THE NETHERLANDS ANTILLES ON RECEIVING THE TOBACCO OR HEALTH COMMEMORATIVE MEDAL AND CERTIFICATE

The Netherlands Antilles is no exception to the long list of nations where the rising costs of health care is becoming a major problem.

In this respect we join the rest of the world, today 31 May 1995, **World No-Tobacco Day,** in focusing attention on the enormous costs tobacco imposes on our societies.

Tobacco extracts an extremely high price on our societies in terms of human suffering, loss of lives, and physical disabilities. We are thus forced to strive for efficiency and efficacy. In order to reduce and control these costs, my Ministry has adopted a health policy centred around the promotion of good health, besides the traditional orientation towards the more curative health care, because we strongly believe that through such a policy we would move more and more towards a society in which we could really achieve health for all, based on the principle of equity.

Prevention of smoking-related diseases is one of the most efficient ways to avoid human suffering, save lives and reduce health care costs deriving from specialized and sophisticated medical care.

While in the past, most of our efforts have been inspired mainly by an individual approach, today we are increasingly focusing our attention on the rights and interests of the generality of the people: on communities, neighbourhoods and the family.

Consequently, we have implemented measures to protect the health and well-being of those who do not smoke, but are victims of the tobacco industry and involuntarily suffer from smoke produced by others. In this respect, my government has introduced legislation prohibiting smoking in public places. In so doing, we have assumed our responsibility as government to promote health and protect the most vulnerable groups.

We hope that in introducing health education programmes, we will be able to build a society where everybody will have equal access to information, which will allow them to make the proper decisions with regard to their health and well-being and that of their fellow-men.

As we believe positively in our youth and that they are our future, much of our health education programmes will be focused on them.

One way we hope to safeguard their future is by introducing health education programmes in the school curricula.

Today is the fifth anniversary of celebrating the 31 May as **No-Tobacco Day** in the Netherlands Antilles. I must say that the celebration of this day has met with positive reaction and enthusiasm from our peoples. Also, a great many initiatives concerning smoking have been implemented since then, thus stressing the importance of commemorating **World No-Tobacco Day.**

I am therefore proud to announce that both our national aviation and television companies have adopted anti-smoking policies. There are also many foundations and religious groups that provide education on smoking, organize courses to quit smoking, and guide and give comfort to those who may have fallen victim to tobacco addiction. We are well on our way in our endeavour to achieve a tobacco-free society, and if I may emphasize it, a tobacco-free global society. However, we still have quite a way ahead of us to go.

The theme of this year's **World No-Tobacco Day** is **The economics of tobacco.**

It doesn't take much calculation for us to realize that only by joining forces we will be abe to counterbalance the mighty and destructive influence of the tobacco empire. In this struggle, we will keep looking up to the World Health Organization and the Pan American Health Organization to lead the way.

EXCERPTS FROM THE MESSAGE BY DR HAKIM MOHAMMED SAID, PRESIDENT HAMDARD FOUNDATION, PAKISTAN

The Hamdard Foundation, Pakistan is a staunch supporter of the world health campaigns launched by World Health Organization, and cooperates, supports and promotes them nationally and internationally. In the last 25 years, Hamdard has waged a sustained, relentless campaign against tobacco and smoking — in schools and colleges, through lectures, essay competitions and creative posters, through the media — films, newspapers, T.V. — against advertising of cigarettes and through national health conferences.

As Federal Minister in the Ministry of Health, Pakistan, I was mainly responsible for having the cautionary line mandatorily printed on every cigarette packet manufactured in Pakistan. One hundred and twenty million people of Pakistan have heard and still hear the message. It is difficult to assess the results of this campaign in actual figures, but we do know that the use tobacco has somewhat declined. Therefore, the tobacco mafia are doing all they can to woo their erstwhile customers back, particularly the younger generation.

World statistics say that whereas smoking has decreased in the developed countries, in some developing countries which are ridden with poverty, ignorance and illiteracy, it is on the increase. Is it because smoking is considered to be a status symbol or is it being encouraged subtly for bringing in greater revenue in the national coffers, careless of the fact that it weakens man's health and his purse? Be that as it may, we need to work harder than ever to make WHO's message percolate through the strata of society and weaken the hold of the tobacco barons.

Like a spreading tree sheltering the birds, the United Nations is an all-powerful protector of the world's nations. The World Health Organization, worthy daughter of a worthy mother, is the world's health conscience. Hamdard and I have heeded to the voice of that conscience. We pledge that our struggle will continue, consonant with the objectives and directives of this conscience, until we have a world free from tobacco and its dangers. This will be our legacy of life and hope to our children.

(Delivered by Mr William d'Silva)

EXCERPTS FROM THE SPEECH BY SIR DAVID HAY, PRESIDENT ELECT, NATIONAL HEART FOUNDATION, NEW ZEALAND

Tobacco or Health medals are symbols of the priority which WHO has given to the tobacco epidemic and we should be grateful to WHO for ensuring that tobacco control has a high place in the health strategies of member countries.

Tobacco consumption fell in New Zealand by 42% between 1984 to 1991, the fastest decline in any western country. The principal reason for this was probably a huge tax increase in 1986 resulting in a 53% rise in the price of cigarettes. Health education achieves its best results when backed up by increased taxes on tobacco.

What concerns us now is that since 1992 smoking prevalence has remained static at 27% for men and women. 38% of young people are smokers and half of all Maori, including nearly two-thirds of young Maori women. On a more optimistic note, Associate Professor R.T. Jackson and his Auckland colleagues are about to publish data from the WHO MONICA Study showing that self-reported smoking in those aged 35-64 years has fallen in men from 28.6% in 1982 to 16.9% in 1993/94 and in women from 24.5 to 14.8%. This 40% decline in smoking was the most significant change among various coronary risk factors and almost certainly has made a major contribution to the 35% reduction in coronary heart disease mortality rates since 1968.

Clearly we are succeeding in reducing smoking in the older age groups and achieving substantial health benefits as a result. We are less successful among the young, particularly women and in those from disadvantaged social and ethnic groups. Our current priority is to press for further tobacco taxation increases as a means of targeting the young and less affluent. I hope they will get the WHO **World No-Tobacco Day** message that **"tobacco costs more than**

you think" and realise that these costs are measured not only in dollars and cents but in addiction and personal health suffering.

We need to be cautious about putting all our smoke-free eggs in one basket, whether this be taxation, legislation, health education, cessation support or anything else. The control of smoking is like the prevention of coronary heart disease: the disorder is multifactorial in origin and action against it requires attack on many fronts. I am often asked why smoking has declined so much in New Zealand and elsewhere over recent decades. **Firstly,** it is because the health message is based on rigorous research evidence which has been overwhelmingly endorsed by the scientific community. It is essential that this scientific base be strengthened constantly by top-quality research.

Secondly, doctors and other health workers have been leaders in promoting the non-smoking message, not only in their one-to-one care of patients, but in their colleges and professional associations, their voluntary charities and in their wider role as citizens. It is essential that health workers continue to lead by example and to acknowledge that we need to be as skilled in advocacy and other health promotion strategies as we are in writing prescriptions or ordering investigations. Those who care for the health of the young have special responsibilities and are faced with the greatest challenges.

Finally, we have by various means made smoking socially unacceptable among many sections of our society and we are now riding this wave and surging forward. There will be no turning back.

The tobacco battle is never over, but at least we know where we are going, can sense victory and intend to achieve it.

EXCERPTS FROM THE ADDRESS BY MR HANS EMBLAD, DIRECTOR, PROGRAMME ON SUBSTANCE ABUSE, WORLD HEALTH ORGANIZATION

It has long been recognized that use of tobacco causes more deaths than all the other drugs of abuse combined. WHO estimates that there are currently 3 million deaths caused by tobacco every year, and the problem will not go away by itself. Moreover, there are many other problems that arise when young people misuse drugs, problems that are also related to tobacco use. Therefore, for interventions to be coherent and effective, all substance use and abuse issues, covering both licit and illicit substance use, need to addressed. WHO's Programme on Substance Abuse does exactly this, and is the only office in the United Nations system to do so. The mandate of the Programme on Substance Abuse is wide, with research, training and programme activities ranging across prevention, health promotion, policy and advocacy, treatment, rehabilitation and regulatory control. With regard to tobacco, however, our highest priority is clear — primary prevention.

There is clear evidence that tobacco is all too often the gateway through which young people pass on their way to the use of other drugs. In countries of North America and some others, this happens at a very young age. The median age at which young people begin to smoke daily is around 14 to 16 and by age 19, 90% of smokers have already begun smoking daily. In North America, very few smokers begin daily smoking after the age of nineteen. In the United States, it has been estimated that 12-17 year-old daily cigarette smokers are 14 times more likely to have binged on alcohol, 32 times more likely to be frequent cocaine users, and 114 times more likely to be frequent marijuana users, compared to their peers who never smoked. The numbers may differ, but tobacco use is probably a significant gateway to other drug use in other countries as well.

The statistics are compelling; a key to all substance abuse prevention is the prevention of tobacco use. Adolescents who never start smoking tobacco will be far less likely to embark on other forms of substance abuse. So prevention of tobacco use benefits public health doubly. Young people will benefit not only from lives free of tobacco addiction, but they will also be more likely to benefit from lives free of all other forms of drug addiction.

These days, we hear a lot about the global war on drugs, and how, despite enormous efforts to control the supply of illicit drugs, illicit drug traffic does not disappear. WHO's Programme on Substance Abuse recognizes that this is a war that must be fought on many fronts, one of the most important being the front of primary prevention. And programmes of primary prevention of illicit drug use and alcohol abuse will all benefit from strong and effective programmes of primary prevention of tobacco use. Of course, preventing tobacco use is neither quick nor easy, and far less dramatic than seizing drugs from international smugglers. In the long run, however, the global wars on tobacco use and drug abuse will be won by us, the foot soldiers of public health, plugging away at building effective comprehensive policies of tobacco and drug control, with a focus on primary prevention. WHO will certainly be doing all it can to shore up the primary prevention front in these battles. We hope we can count on your support.

SPEECH

EXCERPTS FROM THE SPEECH OF MR PATRICK REYNOLDS CITIZENS FOR A SMOKEFREE SOCIETY, USA

My only memories of my father, R.J. Reynolds, Jr., are of a man always short of breath, increasingly sick and frail, and counting the time that he had left to live. My Dad died from emphysema, the result of his life-long cigarette addiction, in 1964, when I was 15.

Cigarettes killed my father,[1] ut still I started smoking. That r ..lly impresses on me how strong the lure of cigarettes is to teenagers. The fact is that a majority of smokers — 60% — begin smoking by the age of 14. And 90% of all those who smoke become addicted before reaching their 19th birthday. That means that only 1 smoker in 10 takes up the habit after age 19.

In 1992, the tobacco industry spent US$ 5 billion on marketing in the US alone. This expenditure translates to about US$ 75 for every adult US smoker, or to US$ 4500 for every US adolescent who became a smoker that year. This apparently high cost to attract a new smoker is very likely recouped over the average 25 years that this teen will smoke.

Tobacco executives maintain that their advertising is only for getting established smokers to switch brands. But most public health advocates agree that cigarette advertising generates new demand, with adolescents being the primary target.

Today, smoking causes 2-3 million deaths each year around the world. And this figure will soon escalate sharply. If current smoking trends persist, smoking will kill half a billion people now alive — about 9% of the world's population!

Who is to blame? First, we can point to the tobacco companies, especially for their predatory marketing campaigns in underdeveloped countries, where people often know little of the dangers of smoking. In some of these nations, cigarette warning labels are often weak or non-existent. And the desire of many Third World peoples for Western cigarettes makes them vulnerable targets indeed.

Second, some governments of the world maintain overly permissive regulation of cigarettes. The buck stops with government — it's up to them to regulate, and not to stand passively by as a new generation of our youth becomes hooked on cigarettes.

The tobacco industry have attempted to portray tobacco regulations as an intrusion on our personal freedoms. But let us remember that there is no freedom in the slavery to nicotine addition. Tobacco is a health issue, not a freedom issue, and even children wonder why cigarette ads are permitted if smoking is so bad for you.

Make no mistake — we need regulation when it comes to tobacco.

Today, on **World No-Tobacco Day,** I would like to take this opportunity to ask publicly to deliver to the leaders of the world a special three-point message.

First, I urge those nations who have not done so already to ban cigarette advertising altogether. There is a clear moral, ethical and legal mandate for all nations to stop the tobacco companies from continuing to associate smoking with positive images of health, sports, success and romance. The tobacco industry can no longer use the old freedom of speech defence, if we separate private speech from commercial speech. Private speech is — and should be — protected by the right of Freedom of Speech. But commercial speech must tell the public the truth. Tobacco ads are outrageous lies, and therein lies the new legal basis for banning tobacco advertising in nations all around the world.

Second, I urge world governments to raise their cigarette taxes, particularly because studies indicate that higher cigarette taxes motivate people to quit, and will substantially reduce future addiction among our youth. I congratulate nations who have imposed the higher cigarette taxes.

Third, I urge world leaders to limit youth access to tobacco. It's a sad reality that most of the world's children today can easily purchase cigarettes.

The tobacco companies have said that, "Smoking is a matter of personal choice." Let's remember that cigarettes are as addicting as heroin or cocaine — and most smokers don't have much choice in the matter. Telling smokers that they have a choice keeps them in denial about this reality, and helps smokers to believe they are smoking because they choose to. This is another way the tobacco companies keep their customers buying their deadly products.

My message for smokers who want to quit is — get into a programme, get help — and keep trying if you fail. Try again — you can do it! Take comfort in the knowledge that most smokers have to quit several times before they stop successfully. And get into a programme — people who win in life ask for help.

I'm going to make you a promise, because I have a strong and clear vision, which I will now share with you. One day there will come a time when the very few people left smoking in the world will each put out their last cigarettes and finally, smoking will be no more. We **will** have a world free of smoking. One day millions of little boys won't be grieving for years over their fathers because of their premature death caused by smoking. No more cancer, no more heart disease, no more lung disease caused by smoking. The day of a smokefree world is coming, and that's a promise. It's coming one day!

NEWS FROM THE REGIONS

ANTI-SMOKING CROSS-COUNTRY RACE IN BRAZZAVILLE

To mark **World No-Tobacco Day** the first cross-country race for health in Brazzaville was organized by the WHO representative's office in the Congo and the national authorities, under the auspices of the WHO Regional Office for Africa. More than 500 participants, including about 60 women, took part in the race which was intended to mobilize the people of the Congo against smoking. "The Congo and the World Health Organization will continue to fight against behaviour that threatens the health of the world in general and the Congolese in particular", stated Mr Jean Mouyabi, Congolese Minister of Health.

Dr Ebrahim Samba, WHO Regional Director for Africa, who presented the prizes to the winners, made an urgent appeal to African governments to put an end to cigarette advertising campaigns and urged them to adopt or strengthen legislation to ban smoking in public places and on public transport. It was regrettable, he maintained, that the few countries in the WHO African Region where the economy is largely dependent on the tobacco industry are contributing to the spread of smoking in the rest of the continent. "It must not be forgotten that tobacco kills", Dr Samba concluded.

GENEVA AND PARIS AGAINST SMOKING

The Tobacco-free Paris Association and the "Information Centre of the Association for the Prevention of Smoking" (CIPRET) of Geneva joined forces on the occasion of **World No-Tobacco Day** on 31 May 1995. This new Franco-Swiss collaboration between two organizations well known for their dynamic and innovative approach will make it possible to devise and carry out joint activities in the field of public health.

WORLD NO-TOBACCO DAY

SPIN-OFFS FROM WORLD NO-TOBACCO DAY 1995 COMMITMENT BY THE UNITED NATIONS

The idea of a tobacco-free world is making headway, particularly within the United Nations system. A number of organizations in various cities of the world expressed their intention to follow WHO's example on the occasion of **World No-Tobacco Day** on 31 May 1995.

The United Nations Office in Vienna, for example, has adopted a new policy on smoking which represents a further step towards a work environment completely free from tobacco smoke. People are now banned from smoking:

- in all offices shared by smokers and non-smokers. Staff who continue to smoke in offices where there are no non-smokers are obliged to keep the doors closed;
- in all areas where for practical reasons smokers and non-smokers cannot be kept apart, for example in meeting and conference rooms of all sizes;
- in all corridors, toilets and other shared premises such as kitchens, photocopying or computer rooms, whether the employee is alone or not.
- The information circular announcing these measures stresses that scientific research has now shown that even passive smoking is harmful for health and causes an increase in respiratory disorders and allergic reactions affecting the eyes, nose and throat.

FAO in Rome also marked **World No-Tobacco Day** by distributing information material on the ill-effects of smoking and by organizing a course for staff members wishing to stop smoking. In a circular to the staff, FAO states its intention to rid its premises of tobacco smoke little by little and, in collaboration with the headquarters and regional staff associations, to introduce more energetic measures than hitherto to restrict smoking. This decision is largely based on the many complaints made by staff members who are exposed to other people's smoke while at work. The circular points out that at the Rome headquarters of FAO smoking is no longer permitted except in a limited number of meeting rooms, in the corridors and on the staircases, and in offices where all the occupants are smokers, provided that the necessary courtesy is displayed towards non-smoking visitors.

However, it is **UNESCO** in Paris which has gone the furthest along this road: following an anti-smoking campaign launched on 1 October 1994 it became a "non-smoking" organization on 1 June 1995, the day after World No-Tobacco Day. In a message addressed to all the staff at the outset of the preparatory campaign, the Director-General of UNESCO, Mr Federico Mayor, announced that, on WHO's recommendation, the United Nations had decided to set an example by restricting or removing opportunities to smoke at the workplace. He believed that a joint effort by staff members to assist each other would show that UNESCO was capable of taking up the challenge by changing its behaviour in regard to a habit that was recognized as harmful to the individual and the community.

TOBACCO OR HEALTH

JAPAN

The smoking prevalence in Japan reached very high levels among males in the middle of the 1960s (about 80%!). Since then the smoking prevalence has declined considerably to the current level of 60%. However, female prevalence is at the same level of 13% in 1992, as it was in 1960. Nonetheless, the number of females smoking at ages 20-24 has been increasing during the last two decades. In 1995, it is estimated that tobacco will cause 12% of all deaths (17% males; 5% females), numbers that are still increasing among males and, on current smoking trends, will eventually also increase among females.

WHO COLLABORATING CENTRE

JAPAN

The Epidemiology Division, National Cancer Centre Research Institute in Tokyo, Japan, was first designated a WHO Collaborating Centre on Smoking and Health in 1982.

Since 1983, Professor Shaw Watanabe has been the head of this Centre. He has given lectures at many medical schools and physicians' associations, and has published several scientific papers.

In 1988, the first workshop attended by Asian experts on tobacco problems was held in Tokyo. Since then there have been an increasing number of anti-smoking activities in Japan. The Centre has built tight links with the Ministry of Health and Welfare to promote tobacco control. During 1994 a committee was established to draw up an action plan for tobacco control, to be proposed in 1995.

The Collaborating Centre has arranged scientific symposiums with the aim of disseminating knowledge on tobacco health hazards, the first of which was held in 1990. Thereafter, these symposiums have been held annually and, in accordance with WHO's **World No-Tobacco Days,** different groups (i.e., health professionals, media people), have been targeted each year.

A Committee for Public Relations has been established within the WHO Collaborating Centre. The activities of the committee focus on the prevention of smoking campaigns on occasions such as the Universiad this year, and at the Winter Olympics Games in 1998 (Nagano). Also, through newspapers, the committee targets business workers with information on the health hazards of tobacco use.

Among the scientific activities being carried out, surveys of smoking prevalence have been continued. Three independent large population-based prospective studies are being conducted by the centre. In one of these studies the total number of participants exceeds 110 000, and another one has been ongoing for 30 years with a re-survey for the survivors now being planned. These cohort studies could be joined to a prospective collaborative study, that will be undertaken to clarify all the tobacco-related deaths in at least 5 — 10 countries. The study will be undertaken in close collaboration with WHO and other institutions.

National Cancer Center Research Institute, Tokyo, Japan

At the national level, the Centre supports various NGO activities, such as the "Smoke-free World for Children" poster contest in Osaka. The network is functioning well with ongoing cooperation with the NGO Council for Tobacco Control, NGO Council of Citizens, Japanese Doctors' and Dentists' Association for the Promotion of anti-smoking, and other groups.

The international collaboration for tobacco control is of high importance. The National Cancer Centre Research Institute collaborates with other WHO Collaborating Centres, and is encouraging them to further improve this collaboration.

The National Cancer Centre Research Institute, being part of an international information network, is ready to transfer the experience of building up "bottom-up action" for tobacco control, to any country where the "top-down" strategy has not been yielding positive returns.

Professor Shaw Watanabe

A NEW COLLABORATING CENTRE ON TOBACCO OR HEALTH

The Division of Public Health at the Skaraborg Institute, Skövde, Sweden, has recently been designated as a WHO Collaborating Centre on the Action Plan for a Tobacco-free Europe. The head of the centre is Chief Medical Officer, Dr Bengt Wramner.

COUNTRY PROFILES

MONITORING THE GLOBAL TOBACCO EPIDEMIC

In order to facilitate the global monitoring of the tobacco epidemic, WHO's Tobacco or Health programme (TOH), in close collaboration with the WHO regional offices, international agencies and regional experts, has been systematically gathering information over the last few years on a number of indicators of direct relevance to the tobacco or health situation in each of the Member States. This information will be published as a compilation of individual country profiles along with regional and global summaries.

As a continuation of examples taken from the *Tobacco or Health Atlas* on monitoring of the global tobacco epidemic (under preparation) the Country Profiles of Argentina and Bangladesh are included in this issue.

ARGENTINA

Socio-demographic characteristics

Population	1990	1995	2025
Total	32,547,000	34,587,000	46,133,000
Adult (15+)	22,586,000	24,651,000	35,917,000
% Urban	86.5	88.1	93.4
% Rural	13.5	11.9	6.6

Health status

Life expectancy (1990-95): at birth: 68.6 (males), 75.7 (females)
at age 15: 58.2 (males), 65.1 (females)

Infant mortality rate in 1990-95: 24 per 1,000 livebirths

Age-standardized death rate per 100,000 in 1990-92 from :

	Ischaemic heart disease	*Cerebrovascular disease*	*Chronic Obstructive Pulmonary Disease**	*Lung cancer*	*All cancers*	*All causes*
Males	127.8	119.1	16.6	55.9	229.8	1,230.4
Females	60.4	85.0	6.3	8.9	141.2	744.5

Socio-economic situation

GNP per capita (US$), 1991: 3,970
GDP per capita (PPP$**$), 1991: 5,120

Average distribution of labour force by sector, 1990-92: Agriculture 13%; Industry 34%; Services 53%

Adult literacy rate (%): Total 96; Male 97; Female 96

* 1980-1985
** PPP$ = Purchasing Power Parity

Tobacco production, trade and industry

Agriculture

In 1990, 52,277 hectares (0.2% of arable land) were harvested for growing tobacco, and it is expected that this amount will increase.

Production and trade

Argentina is one of the major producers of both unmanufactured and manufactured tobacco in the Western Hemisphere. In 1992, 108,570 tonnes of tobacco were produced, an increase of 61% over 1990 (67,588 tonnes), or 1.6% of the world total. In 1990-1993, Argentina produced an annual average of 37,000 million cigarettes, approximately 0.7% of the world total, and imported 2,125 million cigarettes, or 0.5% of the world total. During those years, an annual average of 1150 million cigarettes were exported, although as of 1993, cigarette exports appeared to have fallen considerably. In 1990, export earnings were US$74,000 for cigarettes, and US$95 million for unmanufactured tobacco, while import costs totaled US$70,000 for cigarettes, and US$450,000 for unmanufactured tobacco.

Industry

Cigarette production in Argentina is dominated by two subsidiaries of tobacco multinationals.

As of 1971, around 110,000 farmers were involved in tobacco growing and (in 1987) 2.6% of the non-agricultural workforce was involved with tobacco manufacture and distribution. Tobacco sales account for 7.4% of Argentina's GDP and 4.5% of industrial production.

Tobacco consumption

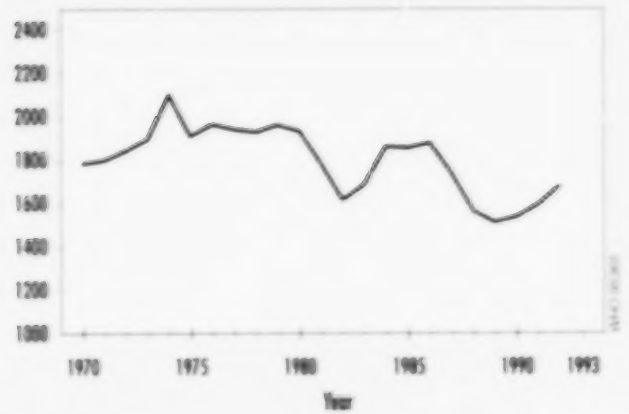
Almost all tobacco consumed in Argentina is manufactured in-country, as there was a ban on imports imposed in 1985. However, a vigorous illegal trade in tobacco with neighbouring countries is reported, and it is estimated that imported contraband cigarettes account for about 12% of the total market. Since 1990, per capita consumption has been increasing steadily, with 1992 and 1993 estimates of 1680 and 1720, respectively (not accounting for illegal imports). Almost all tobacco consumed in Argentina is in the form of manufactured cigarettes.

Consumption of Manufactured Cigarettes

Annual average per adult (15+)

1970-72	1,810
1980-82	1,770
1990-92	1,610

Per Adult Consumption of Cigarettes (age 15+)



Tar/Nicotine/Filters

In 1990, the most popular cigarettes produced in Argentina had tar yields between 13.44 and 18.1 mg, and nicotine yields of 0.9 to 1.0 mg. 100% of the manufactured cigarettes are filter-tipped.

Prevalence

Surveys from 1992 indicate that overall smoking prevalence for adults (18 and older) in Buenos Aires was 31% (men 40%, women 23%), while a previous 1988 survey of adults (18 and older) reported overall prevalence to be 35%, suggesting a slight decline.

Tobacco use among population sub-groups

A 1992 survey reported a higher prevalence of smoking (37%) among lower socio-economic-group adults compared with higher socio-economic groups (21%). In a 1988 survey, the prevalence of smoking among physicians was 45.7% in 1988, and among nurses, 40.0%.

Age patterns

In 1991, a survey of secondary school students (age 15-19) reported an overall prevalence of 14.5% for ever smoking. A 1992 survey reported the highest preva-

lence (37%) among persons aged 18-25 years, and lowest for persons 66-80 years (15%).

Mortality from tobacco use

In the early 1990s, tobacco is estimated to have caused about 14,000 male deaths per year (13% of all male deaths) in Argentina. Tobacco is not yet a major cause of death among women.

Tobacco control measures

Control on tobacco products

In 1986, health warnings on cigarette packs became mandatory. Tobacco advertising is prohibited in publications intended for youth and in theatres to which youth are admitted. Advertising directed at youth is prohibited, and banned from television and radio between 8:00 and 22:00. Distribution of cigarette samples at colleges is prohibited, and single stick sales are banned. In 1989, federal taxes comprised 75% of the average retail price cigarettes.

Protection for non-smokers

Smoking is restricted in health care facilities. In Buenos Aires, smoking is restricted in factories, schools, sports arenas, theatres, and food-processing centres. Smoking is also prohibited on public transport including buses, taxis, and subways.

Health education

Most tobacco control activities have been developed by non-governmental organizations, especially the Argentine Union Against Smoking, the Public Health Foundation, and the Liga Argentina de Lucha Contra el Cancer (LALCEC). Television and radio spots were produced by the Public Health Foundation, and activities have targeted youth through mass media and schools. LALCEC offers smoking cessation classes.

BANGLADESH

Socio-demographic characteristics

Population	1990	1995	2025
Total	108,118,000	120,433,000	196,128,000
Adult (15+)	62,878,000	72,874,000	148,951,000
% Urban	15.7	18.3	40.0
% Rural	84.3	81.7	60.0

Health status

Life expectancy (1990-95): at birth: 55.6 (males), 55.6 (females)
at age 15: 51.0 (males), 50.6 (females)

Infant mortality rate in 1990-95: 108 per 1,000 livebirths

Socio-economic situation

GNP per capita (US$), 1991: 220
GDP per capita (PPP$*), 1991: 1,160

Average distribution of labour force by sector, 1990-92: Agriculture 59%; Industry 13%; Services 28%

Adult literacy rate (%): Total 35; Male 49; Female 23

* PPP$ = Purchasing Power Parity

Tobacco production, trade and industry

Agriculture

In 1993, 47,192 hectares were harvested for tobacco down from 51,855 in 1985. 0.5 % of all arable land is used for tobacco growing.

Production and trade

Since 1990, about 75,000 tonnes of unmanufactured tobacco were produced annually, about 0.7% of the world total. In 1992, Bangladesh produced about 75,000 million manufactured cigarettes and bidis (about 1.3% of world total), up from about 41,000 in 1985. In 1993, earnings from tobacco export amounted to US$ 10 million. Import costs of tobacco rose from US$ 1.7 million in 1985 to US$ 20 million in 1993. The increase was mainly due to an increase of over 500% in tobacco leaf import costs.

Industry

In 1993 about 131,000 people were employed full-time in tobacco leaf processing and tobacco manufacturing, wholesaling and retailing occupations. About 204,500 people are engaged full-time in farming tobacco.

Tobacco consumption

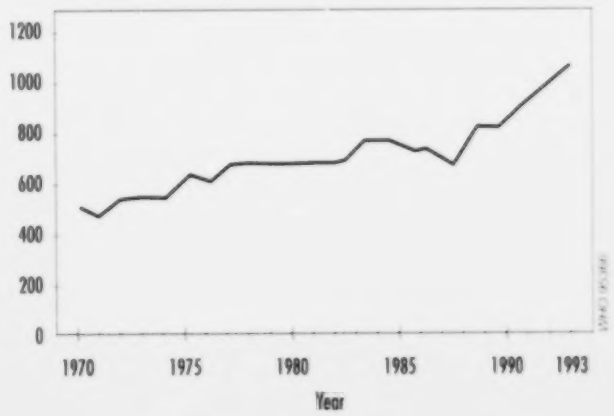
According to surveys in 1979 and 1981, over 80% of all smokers smoked bidis, frequently in addition to other forms of tobacco consumption. Bidi consumption was especially popular among people living in rural and poorer areas. Cigarettes and bidis account for about 70% (by weight) of the tobacco produced, with 20% used for chewing tobacco, and the remainder for cigars, oral snuff, and pipe tobacco. It appears that consumption of bidis continues to increase, while (due largely to an increase in taxes) cigarette sales are declining. The import of manufactured tobacco products is banned, however it is reported that smuggled cigarettes find their way into Bangladesh in large numbers.

Consumption of Manufactured Cigarettes and Bidis*

Annual average per adult (15+)	Cigarettes	Bidis	Total
1970-72	390	120	510
1980-82	310	370	680
1990-92	210	780	990

* Bidi: A small hand-rolled cigarette of unprocessed tobacco, rolled in a tendu leaf

Per Adult Consumption of Cigarettes and Bidis (age 15+)



Tar/Nicotine/Filters

Cigarettes have a tar range of 19-27 mg, with the tar content of bidis being in excess of 23 mg. In 1990, an estimated 7% of all cigarettes produced were filter-tipped.

Relative cost of cigarettes

Average labour time required to purchase a pack of 20 cigarettes is approximately half a day. Bidis, however, are much less expensive, costing only a fraction of the price of cigarettes.

Prevalence

It is estimated that about 60% of men and 15% of women in Bangladesh are smokers. Combined smoking prevalence is about 37%.

Tobacco use among population sub-groups

Since 1980, smoking prevalence among males has decreased from 67% to 60%, but smoking rates for females have increased rapidly, from 1% up to 15% (among female workers in 1980, the smoking rate was already 20%). Smoking prevalence is especially high among lower income groups; for example, 80% of the country's rickshaw pullers smoke. In a 1979 survey of medical students, 28% were found to be smokers, with 94% of them smoking only cigarettes. The smoking rate among physicians increased from around 39% in 1979, to approximately 45% in 1990.

Mortality from tobacco use

The Bangladesh Cancer Society estimates that a significant proportion of all cancers in Bangladesh is related to tobacco use, and that cancers of the oral cavity, pharynx and larynx account for 30% of all cancers. Smoking is also considered to be an important risk factor for male ischaemic heart disease patients in their 40s and 50s in Bangladesh.

Tobacco control measures

Control on tobacco products

Health warnings are required on cigarette packages and in advertisements. However, effectiveness is limited because the warning is small and general in nature, the literacy rate is low, and the warning applies only to domestic and legally imported cigarettes, which account for only a minority of the tobacco consumed in the country.

In 1989 tobacco advertising was banned in most media. Although this ban was respected for some time, now advertisements are widespread. Currently, there are no bans on sales to children.

Annually, US $18.5 million is raised from taxes (on legal cigarettes only), accounting for 8% of total government tax revenue. Cigarette tax increases are scheduled, however.

Protection for non-smokers

Administrative measures to create smoke-free areas have been implemented in hospitals, public transport, elevators, theatres, cinemas and government premises. Some other workplaces have taken voluntary measures to ensure smoke-free areas.

Health education

World No-Tobacco Day is celebrated annually in Bangladesh. Various governmental and non-governmental organizations are actively working to create public awareness through mass media, posters, leaflets, billboards, and seminars. The Consumer Association of Bangladesh is especially active in organizing anti-smoking campaigns over radio and television. High school teachers have to address the hazards of tobacco. The Ministry of Education has provided articles about the hazards of tobacco use for publication in school textbooks. However, in rural Bangladesh, many children do not attend school, and thus do not receive this information.

NEWS FROM THE REGIONS

ASIA: BEIJING ANNOUNCES SMOKING BAN

Officials announced that China's capital Beijing will ban smoking in major public places from October, in a resolution to mark World No-Tobacco Day.

The ban by the Beijing municipal government would make the city China's fourth to weed out the habit in public, Xinhua news agency said.

The commercial metropolis Shanghai, the central industrial city of Wuhan and the northern city of Shenyang already have a ban.

BANGLADESH: WORLD NO-TOBACCO DAY A GREAT SUCCESS

In Bangladesh World No-Tobacco Day is observed annually with great success. In fact, all major decisions on the tobacco issue are taken on World No-Tobacco Days. On these occasions, day-long activities attract all sections of the population, from top politicians, doctors, nurses, teachers, students to rickshaw-pullers. Posters and stickers create an attractive display in the cities. Mobile musical units travelling around the city and suburbs play popular folk songs which carries the message to all types of people, including the illiterate.

The organizers use this opportunity to place their demands/proposals for a successful anti-tobacco campaign before the Head of the State. The response they find is rapid and very encouraging.

World No-Tobacco Day in Bangladesh gives the country an unique opportunity to work together and it is a festive occasion with an enormous impact.

Professor N. Islam
Founder President, ADHL/NK, Dhaka

Children in a primary school in Egypt celebrating the World No-Tobacco Day

NEWS FROM THE REGIONS

WORKSHOP ON SMOKING AND DOCTORS

A special International Union against Cancer (UICC) workshop was held in Beirut during the 2nd Middle East Oncology Congress, on 19-22 April 1995. With participants from Austria, Cyprus, Egypt, France, Jordan, Lebanon, Morocco, Syria and WHO/EMRO.

The following were the final recommendations reached:

1. Clinicians and health workers must have an active role in tobacco or health (TOH) activities.
2. Medical and paramedical personnel should represent good models as non-smokers and should participate actively in TOH activities.
3. The joint contribution of UICC and WHO, technically and financially, is highly recommended in anti-smoking activities in the Middle East.
4. All medical syndicates, associations or societies should play an active role in tobacco or health activities (conducting conferences, producing material, issuing newsletters, guidelines, etc.) and should integrate the TOH activities as part of their daily activities and urge their members to integrate anti-smoking activities in their daily practices.
5. All hospitals and health care facilities must be tobacco smoke-free premises.
6. Curricula of medical schools should contain knowledge and information about smoking related to hazardous diseases.
7. Health authorities concerned (Ministry of Health, medical associations, research institutions, etc.), in the Middle East should contribute and participate actively in conducting research and surveys on smoking-related morbidity and mortality. Medical societies in each country must act as pressure groups on their government to produce legislation controlling tobacco consumption and to enforce the implementation of any existing legislation.

Dr Sherif Omar, Egypt

USA: NATIONAL ASSOCIATION OF AFRICAN-AMERICANS FOR POSITIVE IMAGERY

In the United States, more than 120 communities held World No-Tobacco Day activities on 31 May. For the second year, the National Association of African Americans for Positive Imagery (NAAAPI) served as facilitator for many of these community activities. The largest World No-Tobacco Day ceremonies were held in the cities of Philadelphia, Los Angeles and Boston, where hundreds of men, women and children gathered in the streets for Memorial Services that featured symbolic coffins, horse-drawn hearses, traditional music and the recitation of names of those who had died from tobacco. In some communities, tobacco billboards were draped in black to highlight the impact of targeted marketing of tobacco products. NAAAPI commemorates the World Health Organization's **World No-Tobacco Day** annually as a way to show solidarity worldwide in the fight against tobacco.

Reverend Jesse W. Brown, Jr., President NAAAPI, and Director, Churches Organized to Stop Tobacco (COST). COST is a collaborative effort of the Medical Foundation and six churches. It is the first Massachusetts programme to develop a church-based smoking education, prevention and cessation model to reduce the prevalence of tobacco initiation, use and mortality amongst African Americans.

QUESTIONNAIRE

We are currently in the process of updating our mailing list, and we would appreciate your taking a few minutes to answer the following questions:

- **Please inform us of any changes to your name and address:**

_____

_____

_____

- **Do you wish to be kept on our mailing list?** ☐ **Yes** ☐ **No**
- **Do you translate at least part of each issue for publication in your country?** ☐ **Yes** ☐ **No** **If yes, in what language(s)?** _____
- **Are you in contact with your WHO Regional Office?** ☐ **Yes** ☐ **No**

Please send above information to: Programme Manager, Tobacco or Health Programme on Substance Abuse, World Health Organization, 1211 Geneva 27, Switzerland.

Ashim, B., a Bangladeshi student of class 3, was awarded the gold medal in the poster competition organised by the Asia Pacific Association for Prevention of Tobacco, Japan.

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The following have contributed to this issue:

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